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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13030 13001

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Northampton	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manokin		c. LENGTH OF STAY IN 1b Exmore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Age Home		d. STREET ADDRESS 83X-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		094	
3. NAME OF DECEASED (Type or print) Rosie		First Badger	Middle
4. DATE OF DEATH Nov. 20, 1960	Month Nov.	Day 20	Year 1960
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 19, 1884
9. AGE (in years last birthday) 76	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME William Harmonson		14. MOTHER'S MAIDEN NAME Annie Hatchett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT George Scarborough	Address Crisfield, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic GastroEnteritis		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
572.3 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Haemorrhage			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 15th 1958 to Nov. 20, 1960 that (I) (we) last saw the deceased alive on Nov. 19th 1960 and that death occurred at 5 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Eldon G. Marksman		22b. DATE SIGNED 11-21-60	
22c. PHYSICIAN'S NAME (Type) Eldon G. Marksman	22d. ADDRESS Princess Ann, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 27, 1960	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary Cem.	23d. LOCATION (City, town, or county) (State) Exmore, Va.
24. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton	ADDRESS New Church, Va.	25a. REC'D BY REGISTRAR DATE NOV 28 '60	25b. REGISTRAR'S SIGNATURE Collie S. Tamm

10001

10001

10001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13031 CERTIFICATE OF DEATH 13002

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Vernon		c. LENGTH OF STAY IN 1b 6 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Vernon		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Gertrude				Bowland	II	3	19	60	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/10/1894		9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY House Wife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Doane		14. MOTHER'S MAIDEN NAME Martha Doane							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Madeline Pinkett, MT Vernon, Md		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Hypertension (c)		myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH One week			
34 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 30, 1950, to Nov 3, 1960, that I last saw the deceased alive on Sept 30, 1960, and that death occurred at 11:00 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Sept 30, 1960 G. Markman M.D.		ADDRESS (Street, city or town, state) Princess Anne, Maryland DATE SIGNED							
PHYSICIAN'S NAME (Type) Elton G. Markman		Princess Anne, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/60		22c. NAME OF CEMETERY OR CREMATORIAL ST Marks		22d. LOCATION (City, town, or county) Oakville, Md (State)			
23. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr. Princess Anne, Md		ADDRESS		24a. REC'D BY REGISTRAR NOV 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13003

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 10 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION E.W. McCREADY MEMORIAL HOSP.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARION STATION	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First BEATRICE	Middle MAE	Last BUNDICK
4. DATE OF DEATH	Month NOVEMBER	Day 27	Year 1960
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JAN 26, 1890
9. AGE (In years lost birthday) 70 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) VIRGINIA	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WILLIAM TAYLOR	14. MOTHER'S MAIDEN NAME EUGENIA KNIGHT		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	INFORMANT STACIUS BUNDICK	Address MARION STATION MD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Scleroderma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X (b) Chronic Osteoarthritis (c) Diabetes mellitus. INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) General Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1960		
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 17 , 19 60 to Nov 27 , 19 60 , that I last saw the deceased alive on Nov 27 , 19 60 , and that death occurred at 1:40 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George C. Coulbourn</i>	ADDRESS (Street, city or town, state) M.D. DATE SIGNED		
PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D., MARION STATION, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 1, 1960	22c. NAME OF CEMETERY OR CREMATORIUM St. Paul's Cemetery	22d. LOCATION (City, town, or county) (State) Marion Station, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland	ADDRESS	24a. REC'D BY REGISTRAR DATE DEC 5 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Khan

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13033

CERTIFICATE OF DEATH

13004

1. PLACE OF DEATH o. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pocomoke City		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First SIDNEY	Middle HAROLD	Last CAREY
4. DATE OF DEATH November	Month 30	Day 1960	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1929
9. AGE (In years last birthday) 31 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant	11. KIND OF BUSINESS OR INDUSTRY General Store	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Oliver Pittman Carey	14. MOTHER'S MAIDEN NAME Louise Mills	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. Korean	17. INFORMANT R.F.D. 1 Frederick W. Carey, Pocomoke City, Md.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO DUE TO (c) Coronary Occlusion	19. INTERVAL BETWEEN ONSET AND DEATH 1 hour
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21. I certify that (I) (this hospital) attended the deceased from <u>May 8</u> 1960 to <u>Nov. 30</u> 1960, that (I) (we) last saw the deceased alive on <u>Nov. 30</u> 1960 and that death occurred at <u>5p.m.</u> from the causes and on the date stated above.		
22. MEDICAL CERTIFICATION Signature Charles W. Trader, M.D.		22b. DATE SIGNED 12-1-60	
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS 302 Market St., Pocomoke City, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-3-60	23c. NAME OF CEMETERY First Baptist	23d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Henry A. Watson	ADDRESS Pocomoke City, Md.	25a. REC'D BY REGISTRAR DATE DEC 5 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13034

CERTIFICATE OF DEATH

Reg. Dist. No.

13005

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 32 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION E.W. MCCREADY MEMORIAL HOSP.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TANGIER	
3. NAME OF DECEASED (Type or print) EYDELLA		First E	Middle YDELLA
4. DATE OF DEATH DALEY		Month NOVEMBER	Day 4
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 4-5-1898		9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) TANGIER, VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES H CROCKETT		14. MOTHER'S MAIDEN NAME ELIZABETH SHORES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT ROSE PARKS TANGIER, VIRGINIA		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOSARCOMA ABDOMINAL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to Nov 4th , 19 60 that I last saw the deceased alive on NOV 4TH , 19 60 , and that death occurred at 12:15 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) TANGIER, VA.			
ACTUAL SIGNATURE <i>Charles W. Lithgow</i>		DATE SIGNED 11-4-60	
PHYSICIAN'S NAME (Type) CHARLES H LITHGOW, MD		CRISFIELD, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov-6-1960	
22c. NAME OF CEMETERY WHEATLEY		22d. LOCATION (City, town, or county) TANGIER, VA.	
23. FUNERAL DIRECTOR'S SIGNATURE S. J. Webster Crisfield MD		24a. REC'D BY REGISTRAR NOV 9 '60	
ADDRESS 13034		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

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CHARGE OF GUNS

1902

1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13035

CERTIFICATE OF DEATH

13006

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairmount Rd.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MANNIE	Middle H.	Last DENNIS
4. DATE OF DEATH	Month November	Day 14	Year 1960
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1898
9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Farm & Seafood	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Arzie Dennis		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT James Dennis, Westover, Maryland	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Hemorrhage DUE TO 33IX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO (c) Hypertension			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) (d) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 12 1960 to Nov 14 1960 , that (I) (we) last saw the deceased alive on Nov 11 1960 , and that death occurred at 7:30p from the causes and on the date stated above.			
22a. SIGNATURE <i>E. G. Marksman</i>		22b. DATE SIGNED 11-17-60	
22c. PHYSICIAN'S NAME (Type) E. G. Marksman, M. D.		22d. ADDRESS Princess Anne, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 18, 1960	23c. NAME OF CEMETERY OR CREMATORIAL Lawsonia Cemetery	23d. LOCATION (City, town, or county) Crisfield, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland	ADDRESS	25a. REC'D BY REGISTRAR DATE NOV 22 '60	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

ITAMO RIVER 1972

July 2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13007

13036

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY SOMERSET		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY SOMERSET		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		d. STREET ADDRESS 18 ELZEY LANE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. McCREADY MEMORIAL HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First JAMES	Middle CHARLES	Last ELZEY	4. DATE OF DEATH NOVEMBER	Month NOVEMBER	Day 13	Year 1960	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 13, 1902	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Year 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 勞工	10b. KIND OF BUSINESS OR INDUSTRY Seafood	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME CHARLES ELZEY	14. MOTHER'S MAIDEN NAME Maggie Roach							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 217-05-5929	17. INFORMANT Mrs. Earl Daniel, Brooklyn, N. Y.	Address 328 Madison St., Brooklyn, N. Y.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis Liver								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Alcoholism, chronic?								
DUE TO (c) years -								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture, left humerus								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 6P						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Crisfield	(County) Maryland	(State) Maryland
21. I certify that (I) (this hospital) attended the deceased from 10 - 24 1960 to 11 - 13 1960 , that (I) (we) last saw the deceased alive on 11 - 13 1960 , and that death occurred on 6P M, from the causes and on the date stated above.								
22a. SIGNATURE C. G. Rawley.				M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED NOV 18 1960			
22c. PHYSICIAN'S NAME (Type) C. G. Rawley, M.D.				22d. ADDRESS CRISFIELD, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE THEREOF Nov. 16, 1960	23c. NAME OF CEMETERY OR CREMATORIUM Lawsonia Cemetery			23d. LOCATION (City, town, or county) Crisfield, Maryland			(State)
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland	ADDRESS			25a. REC'D BY REGISTRAR NOV 18 '60		25b. REGISTRAR'S SIGNATURE Clifford S. Thomas		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

M

13008

Reg. Dist. No.

13027

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE					
Somerset		Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print)		First James	Middle Beauchamp	Last Hill	4. DATE OF DEATH	Month Nov. 26,	Day Year 1960
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1YEAR Months	IF UNDER 24 HRS. Days	
Male	white	WIDOWED <input checked="" type="checkbox"/>	Divorced <input type="checkbox"/>	June 20, 1875	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hix. Pond Gap, W.V.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lorenzo D. Hill		14. MOTHER'S MAIDEN NAME Mary Currence					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Marshall Hill, Princess Anne, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Senility and Exhaustion, Cardiac Failure					
S 40 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Gastric Ulcers.				Years	
		DUE TO (c) Anorexia				10 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>R. H. Johnson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 11/28/60	
EXAMINER'S NAME (Type)		R. H. Johnson, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/29/60	22c. NAME OF CEMETERY OR CREMATORIAL St. Andrews Episcopal		22d. LOCATION (City, town, or county) Princess Anne, Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Sherman</i>		ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR NOV 30 1960	24b. REGISTRAR'S SIGNATURE <i>Albert S. Miller</i>	DATE	

1120 *Journal of Health Politics, Policy and Law*

20

10

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13028 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13009

Reg. Dist. No.

TO DEPUTED MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

M

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D

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1. PLACE OF DEATH a. COUNTY Somerset			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Somerset					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Mary	Middle Ellen	Last Layfield	4. DATE OF DEATH Nov. 26 1960	Month Nov.	Day 26	Year 1960
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1872		9. AGE (in years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Augustus Harvey			14. MOTHER'S MAIDEN NAME Martha Clark					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Virginia Layfield, Princess Anne, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary heart disease DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis 2-3 years DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE R. H. Johnson, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type)		DATE SIGNED 11/28/60						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/60		22c. NAME OF CEMETERY OR CREMATORIAL Manokin Presbyterian		22d. LOCATION (City, town, or county) Princess Anne, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE James Hennigan		ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR DATE NOV 30 '60		24b. REGISTRAR'S SIGNATURE C. L. Kraus		

18. *INTERACTIVE DIALOGUE: A CREDIBLE STATE OF DEATH* — GREGORY S. GREGORY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13037

CERTIFICATE OF DEATH

13010

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Somerset		a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Somerset	
East Princess Anne		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
First Violz		Last Long	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Month Nov. Day 17 Year 1960	
5. SEX Female Negro		6. COLOR OR RACE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH April 13, 1903	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		11. BIRTHPLACE (State or foreign country) East Princess Anne	
13. FATHER'S NAME Richard Miles		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 214-28-4079	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INFORMANT Miss Violz Miles-E. Princess Anne, MD	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Address	
Uremia		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
442X		years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Arterionephrosis of kidneys	
DUE TO (b)		years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on 11-17-60, 19		to 11-17-60, 19, that I last saw the deceased	
and that death occurred at 8:15PM		, from the causes and on the date stated above.	
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state) Dames Quarter, Maryland	
PHYSICIAN'S NAME (Type)		DATE SIGNED 11-18-60	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Nov. 20 1960	
Burial		22c. NAME OF CEMETERY OR CREMATORIAL Oakville	
23. FUNERAL DIRECTOR'S SIGNATURE		22d. LOCATION (City, town, or county) (State) East Princess Anne, Somerset, Md.	
Charles H. Stark-Marion Sta., Md. #235		24a. REC'D BY REGISTRAR NOV 28 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Thrus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13011

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Princess Anne		d. STREET ADDRESS Mt. Vernon Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Mt. Vernon Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Jennie	Middle D.	Last Smullin	4. DATE OF DEATH	Month November	Day 14, 1960	Year
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16, 1888	9. AGE (in years last birthday) 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Stephen Pilchard				14. MOTHER'S MAIDEN NAME Mary Francis Scott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT John Smullin		Address Princess Anne, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) DUE TO Carcinoma of uterus with generalized metastasis INTERVAL BETWEEN ONSET AND DEATH 1 year 174X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour a. m. p. m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20d. INJURY OCCURRED 3-11-57	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.	20f. (City or town) 11-14-60	(County)	(State)
21. I certify that I attended the deceased from alive on		11-14-60	19	19	19	1:30 PM	19
ACTUAL SIGNATURE <i>Everett C. Sutter</i>		ADDRESS (Street, city or town, state) Dames Quarter, Maryland 11-15-60					
PHYSICIAN'S NAME (Type)		DATE SIGNED 11-15-60					
22a. BURIAL, CREMATION, burial (Specify)		22b. DATE THEREOF 11/16/1960	22c. NAME OF CEMETERY OR CREMATORY St. Andrews	22d. LOCATION (City, town, or county) Princess Anne, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>James L. Lunn</i>		ADDRESS Princess Anne, Md.	24a. REC'D BY REGISTRAR DATE NOV 22 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

comes along, making it fit-
for me to do.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13026

CERTIFICATE OF DEATH

13012

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Office, Dr. Sarah M. Peyton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
3. NAME OF DECEASED (Type or print) GORDON		First RICHARD	Middle STERLING
4. DATE OF DEATH November	Month 2	Day 1960	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1912
9. AGE (In years last birthday) 48	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleman	11. KIND OF BUSINESS OR INDUSTRY Bakery Products	12. BIRTHPLACE (State or foreign country) Crisfield, Maryland
13. FATHER'S NAME Gordon R. Sterling	14. MOTHER'S MAIDEN NAME Mary Tyler	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 215-05-5401	17. INFORMANT Mrs. Dorothy B. Sterling, Crisfield, Maryland	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Crisfield	(County) Maryland	(State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 2, 1960 , to Nov. 2, 1960 , that (I) (we) last saw the deceased alive on Nov. 2, 1960 , and that death occurred at 9:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Sarah M. Peyton		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Sarah M. Peyton, M. D.		22d. ADDRESS 33 W. Main St., Crisfield, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 6, 1960	23c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery	23d. LOCATION (City, town, or county) Crisfield, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		ADDRESS	25a. REC'D BY REGISTRAR DATE NOV 9 '60
			25b. REGISTRAR'S SIGNATURE Arthur S. Traas

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Quarantine

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13038

13013

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Life		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD, Lawsonia			d. STREET ADDRESS RFD, Lawsonia		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First ISAAC	Middle THOMAS	Last TYLER	4. DATE OF DEATH November 8 1960	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 31, 1885	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Packer		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Thomas Benton Tyler			14. MOTHER'S MAIDEN NAME Nancy Jane Lawson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-32-7071		17. INFORMANT Address Mrs. Carrie M. Tyler, Lawsonia, Crisfield, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.					
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease 1 yr.					
DUE TO (c) Myocardial Infarction 7 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 8 1960 to Nov 8 1960 , that (I) (we) last saw the deceased alive on Nov 8 1960 and that death occurred at 8:15 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Sarah M. Peyton					
22b. DATE SIGNED 22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) Sarah M. Peyton, M. D.					
22d. ADDRESS 33 W. Main St., Crisfield, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 11, 1960	23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery		23d. LOCATION (City, town, or county) Crisfield, Maryland (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland			ADDRESS		
			25a. REC'D BY REGISTRAR DATE NOV 16 '60		
			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

